

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 11933
County Wicomico

Village or City Salisbury (No. Candiant St. 13 Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sibbey W. Adams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH July 18, 1913
(Month) (Day) (Year)

7 AGE 1 yrs. 4 mos. 1 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER John W Adams

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Etha C Ennis

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W Adams

(Address) Salisbury Md

15 Nov 18, 1914 REGISTRAR V. B. Bunker

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 18, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1914, to Nov 18, 1914.

that I last saw him alive on Nov 18, 1914.

and that death occurred on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Empyema following pneumonia

From hunting to much
(Duration) yrs. mos. ds.

Contributory Empyema
Secondary

(Duration) yrs. mos. ds.

(Signed) D. J. Wicks, M. D.

Nov 18, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Grave DATE OF BURIAL Nov 18, 1914

20 UNDERTAKER Halloway & Co ADDRESS Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1914
BUREAU, V.S.

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PLACE OF DEATH 11934

County

Wicomico

P. G. Hosfield

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

Village or City

Salisbury

(No.

Canaan dist.

St. 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Arthur L. Atkinson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH

Nov 28th, 1914
(Month) (Day) (Year)

7 AGE

0 yrs. 0 mos. 2 ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Salisbury Md.

PARENTS

10 NAME OF FATHER

Arthur P. Atkinson

11 BIRTHPLACE OF FATHER (State or country)

Worcester Co. Md.

12 MAIDEN NAME OF MOTHER

Marie E. Townsend

13 BIRTHPLACE OF MOTHER (State or country)

Worcester Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur P. Atkinson

(Address)

Mayland Ave. East Salisbury Md.

15

Filed

Nov 30th, 1914. M. Turner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 30, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Did not attend. Except as Confirmed by

that I last saw him alive on Nov. 29, 1914

and that death occurred on the date stated above, at 3 PM, m.

The CAUSE OF DEATH was as follows:

My wife was found dead during the night. Premature birth is the only cause I know of.

(Duration) yrs. mos. ds.

Contributory Secondary Child never seemed well but we did not know what the matter was

(Duration) yrs. mos. ds.

(Signed) M. D.

Nov. 30, 1914. (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parsons Cem. Salisbury Md. Nov. 30th, 1914

20 UNDERTAKER

ADDRESS

Geo. C. Hill Salisbury Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

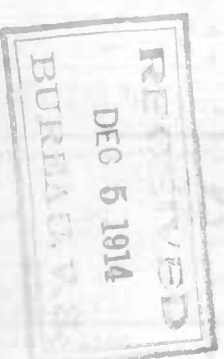
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Tirecurey*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Malaria* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH 11935 STATE OF MARYLAND
County Thicomico 157 CERTIFICATE OF DEATH
Registration Dist. No. _____

Village or City Willards (No. _____) St. _____ Ward _____
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mabel Anna Beauchamp

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Femine 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant
(Write the word)

6 DATE OF BIRTH April 21st, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. 7 mos. 4 ds. OR _____ min. ?
If LESS than 1 day, _____ hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER James L. Beauchamp
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary Jones
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Beauchamp
(Address) Willards Md

15 Filed Nov 28 1914 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 26, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1914, to Nov 28, 1914,

that I last saw her alive on Nov 28, 1914,

and that death occurred on the date stated above, at 5:10 A m,

The CAUSE OF DEATH* was as follows:

marasmus

(Duration) _____ yrs. 2 mos. _____ ds.
Contributory Purpura Haemorrhagica
Secondary _____

(Signed) J. O'Brien, M. D.
Nov 26, 1914 (Address) Pittsville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Mt Pleasant, Md. DATE OF BURIAL Nov 26, 1914

20 UNDERTAKER J. Ratliff Farlow ADDRESS Willards, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11936
 County Wicomico 82
 Village or City White Haven (No. _____) St.; _____ Ward) _____
2 FULL NAME Emma Bloodworth

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 387

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female **4 COLOR OR RACE** White **5 MARRIED, WIDOWED, OR DIVORCED** Married
 (Write the word)
6 DATE OF BIRTH Mar 21, 1878
 (Month) (Day) (Year)
7 AGE 38 yrs. 9 mos. 21 ds. **8** If LESS than 1 day, _____ hrs. OR _____ min. ?

9 OCCUPATION
 (a) Trade, profession, or particular kind of work House Wife
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Somerset Co. Md.

10 NAME OF FATHER Jemie Williams

11 BIRTHPLACE OF FATHER (State or country) Wicomico Co. Md.

12 MAIDEN NAME OF MOTHER Lacy Simms

13 BIRTHPLACE OF MOTHER (State or country) Somerset Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Bloodworth

(Address) White Haven

15 Filed Dec 1st, 1914 L. H. Haller REGISTRAR
Local

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 30, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 10, 1914, to Nov 30, 1914.

that I last saw he alive on Nov 29, 1914

and that death occurred on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Embolism of the Brain

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. A. Barr, M. D.
Nov 30, 1914 (Address) Frederick

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Somerset Co **DATE OF BURIAL** Dec 2, 1914

20 UNDERTAKER C. G. Messick **ADDRESS** Frederick

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

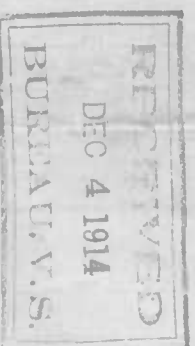
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 11937 28
 County Wicomico
 Village or City Prine Bluff Janatyn near Salisbury Md (No. Camden dist St. 13 Ward)
 Registration Dist. No. 333
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Annie Lee Bowen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH June 1891
 (Month) (Day) (Year)

7 AGE about 23 yrs. 6 mos. — ds. — hrs. — min. ?
 If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work house wife
 (b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James Thomas

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Andea Powell

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Bowen

(Address) Berlin Md.

15 Nov 14, 1914 A. L. Bowen
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 14, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1914, to Nov. 14, 1914.

that I last saw her alive on Nov. 13, 1914.

and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis & Larynx (Duration) about yrs. how mos. ds.

Contributory Secondary
Tuberculosis (Duration) about yrs. how mos. ds.

(Signed) Dr. H. J. Todd M. D.
Nov. 14, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL near Berlin Md. DATE OF BURIAL Nov. 16, 1914

20 UNDERTAKER Synonymus Church of ADDRESS Berlin Md.

J. B. Burroughs

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

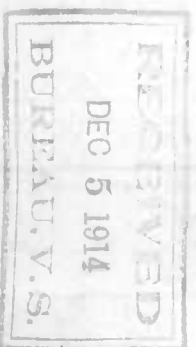
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Uæmia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

11938

County WicomicoSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Salisbury (No. 61 Camden Dist. 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Helene L Carey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH April 18, 1909
(Month) (Day) (Year)

7 AGE 5 yrs. 7 mos. 2 ds. OR 1 day. 1 hrs. 1 min. ?
IT LESS than 1 day.

8 OCCUPATION
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Sidney P Carey

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Maud F E Bell

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sidney P Carey(Address) Salisbury Md

15 Nov 21, 1914. M. J. Turner
FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 20, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1914, to November 20, 1914, that I last saw h. alive on Nov 19, 1914.

and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Intestinal
acute meningitis
(Duration) — yrs. — mos. — ds.

Contributory acute
Secondary —

(Signed) Shorris, M. D.
Nov 21, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Salisbury Md DATE OF BURIAL Nov 21, 1914
Barbours Cemetery

20 UNDERTAKER Holloway & Co ADDRESS Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

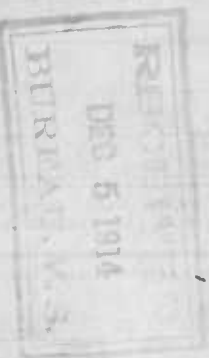
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc.; *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary, 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Kiconia</u>		11939 <u>28</u>		STATE OF MARYLAND CERTIFICATE OF DEATH Camden Registration Dist. No. <u>333</u>	
Village or City <u>near Price Bluff Sanatorium</u> <u>Salisbury</u> (No. <u>Camden Dist. 13</u> Ward)		2 FULL NAME <u>Mellie E. Carey</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)			
6 DATE OF BIRTH <u>March 24</u> , 18 <u>39</u> (Month) (Day) (Year)					
7 AGE <u>70</u> yrs. <u>7</u> mos. <u>19</u> ds. OR LESS than 1 day, ____ hrs. ____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>General House</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>work</u>					
9 BIRTHPLACE (State or country) <u>Don't Know</u>					
PARENTS	10 NAME OF FATHER <u>Harry Shackley</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Don't Know</u>				
	12 MAIDEN NAME OF MOTHER <u>Don't Know</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Don't Know</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo. H. Todd Jr</u> <u>Ms Lafayette Todd</u> (Address) <u>Salisbury Md</u>					
15 <u>Nov 14</u> , 19 <u>14</u> <u>4</u> <u>W. Turner</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov. 13</u> , 19 <u>14</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>July 8</u> , 19 <u>14</u> , to <u>Nov. 13</u> , 19 <u>14</u> , that I last saw her alive on <u>Nov 13</u> , 19 <u>14</u>					
and that death occurred on the date stated above, at <u>10-30</u> a.m. The CAUSE OF DEATH* was as follows:					
<u>Phthisis Pulmonary & Tuberculosis of Bronch</u> (Duration) <u>about 2</u> yrs. <u>2</u> mos. <u>2</u> ds.					
Contributory <u>Tuberculosis</u> (Duration) <u>Don't know</u> yrs. <u>Don't know</u> mos. <u>Don't know</u> ds.					
(Signed) <u>Geo. H. Todd</u> M. D. <u>Nov. 13, 1914</u> (Address) <u>Salisbury Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? ____ Former or usual residence ____					
19 PLACE OF BURIAL OR REMOVAL <u>Delmar Del.</u> <u>Hastings Cemetery</u>				DATE OF BURIAL <u>Nov 15</u> , 19 <u>14</u>	
20 UNDERTAKER <u>M. W. Ellis</u>				ADDRESS <u>Delmar</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

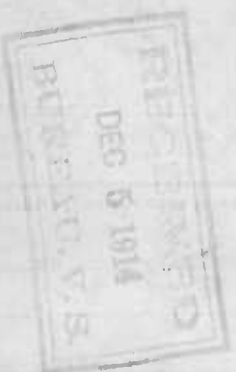
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 11940
 County Wicomico 120
 Village or City Salisbury (No. _____, _____ St.; 13 Ward)
 Registration Dist. No. 333
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Emor Frances Chatham

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
 (Write the word)

6 DATE OF BIRTH May 12th, 1846
 (Month) (Day) (Year)

7 AGE 68 yrs. 6 mos. 14 ds. OR 1 day, 1 hrs. 1 min. ?
 If LESS than

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
 10 NAME OF FATHER John E. Robertson
 11 BIRTHPLACE OF FATHER (State or country) Maryland
 12 MAIDEN NAME OF MOTHER Diadema Denson
 13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kettie Barry
 (Address) Salisbury Maryland

15 Filed Nov 28, 1914. Inay Turner
Deputy REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 28, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sep 17th 1914, to Nov 27, 1914,
 that I last saw her alive on Nov 27, 1914,

and that death occurred on the date stated above, at 1 P m.
 The CAUSE OF DEATH* was as follows:

Nephritis
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory Rheumatism
 Secondary (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. R. Smith, M. D.
Nov 28, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted,
 If not at place of death?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Persons Cem. Salisbury Md. Nov. 29th 2 P.M., 1914
 20 UNDERTAKER ADDRESS
Geo. C. Hill Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

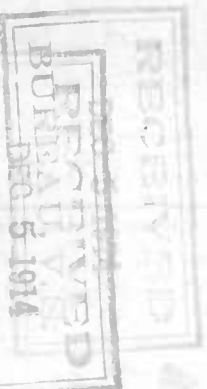
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH 11941

County WicomicoVillage or City Salisbury (No. Parsons dist St.; 5th Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary P. Collins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH May 10th, 1829
(Month) (Day) (Year)

7 AGE 85 yrs. 5 mos. 26 ds. OR 1 day, 5 hrs. 26 min. ?
if LESS than

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Delaware

PARENTS
10 NAME OF FATHER Jacob Elliott
11 BIRTHPLACE OF FATHER (State or country) Delaware
12 MAIDEN NAME OF MOTHER Sallie Moore
13 BIRTHPLACE OF MOTHER (State or country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel Hearn(Address) Salisbury, Md. R. F. D.

15 Nov 6th, 1914 W. H. Hearn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 6, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Aug 1, 1914 to Nov 6, 1914,
that I last saw her alive on Nov 4, 1914

and that death occurred on the date stated above, at 4 a.m.
The CAUSE OF DEATH* was as follows:

Paralysis
since Aug 1st 1914
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory Paralysis
Secondary (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) H. T. Craven, M. D.
Nov 6, 1914 (Address) Salisbury, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL On Jason Tilghman farm DATE OF BURIAL Nov 8th, 1914

20 UNDERTAKER Geo. C. Hill ADDRESS Salisbury, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

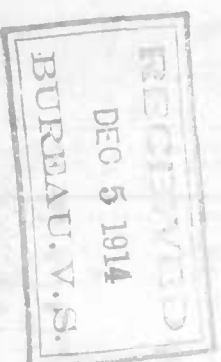
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 11942

County Wilcomulco
 Near Wellman (No. Parsons Inst St.; 5 Ward)
2 FULL NAME Geo. W. CrockettSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Male 4 COLOR OR RACE A. A. 5 SINGLE, MARRIED, yes, WIDOWED, OR DIVORCED Married
(Write the word)

 6 DATE OF BIRTH July 2, 1888
(Month) (Day) (Year)

 7 AGE 26 yrs. 4 mos. 23 ds. OR 1 day, 23 hrs. 5 min. ?
If LESS than 1 day,.....hrs.

 8 OCCUPATION
(a) Trade, profession, or particular kind of work Railroad work
(b) General nature of industry, business, or establishment in which employed (or employer)

 9 BIRTHPLACE (State or country) Maryland

 PARENTS
10 NAME OF FATHER William Crockett
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Hester Carroll
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hester Carroll(Address) Laurel Hill
 15 Nov 26, 1914 A. B. Guerner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH 11 26, 1914
(Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1914, to Nov 26, 1914,
that I last saw him alive on Nov 23, 1914.and that death occurred on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Infarction of lungs(Duration) 1 yrs. 0 mos. 0 ds.Contributory none
Secondary(Duration) 1 yrs. 0 mos. 0 ds.(Signed) A. B. Guerner, M. D.Nov 26, 1914. (Address) Laurel Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

 At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Union Cemetery DATE OF BURIAL Nov 27, 191420 UNDERTAKER J. F. Stewart ADDRESS Baltimore Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

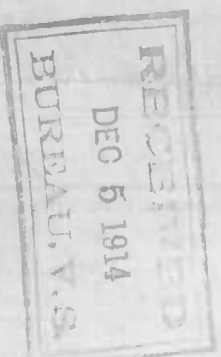
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., or..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11943

County

Wicomico

Village or City

White Haven

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 337.

2 FULL NAME

Mabel Dashiell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

March 29, 1885
(Month) (Day) (Year)

7 AGE

29 yrs. 3 mos. 19 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Wm. F. Langrall

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Virginia Corington

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Dashiell

(Address)

White Haven Md

15

Filed

Nov. 11, 1914

L. P. Walter

Local REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 10, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 7, 1914, to Nov 10, 1914.

that I last saw him alive on Nov 10, 1914

and that death occurred on the date stated above, at 3:20 A. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis due to Pregnancy
Uremia

(Duration) yrs. mos. 14 ds.

Contributory Secondary

Pregnant State

(Duration) yrs. mos. ds.

(Signed)

R. E. Castwell

M. D.

Nov 11, 1914 (Address) Bowie Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dyaskin M & Co

Nov 12, 1914

20 UNDERTAKER

ADDRESS

C. G. Murrish

Bowie Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECORDED
DEC 4 1914
BUREAU. V. S.

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1 PLACE OF DEATH County <u>Clarence</u> 11944		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Clara</u> (No. _____) St.; _____ Ward _____		Registration Dist. No. <u>337</u>	
2 FULL NAME <u>Infant Sarah E. Dashiell</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	
6 DATE OF BIRTH <u>Oct 17, 1914</u> (Month) (Day) (Year)			
7 AGE <u>1</u> yrs. <u>7</u> mos. <u>7</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Grant Dashiell</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Mary E. Nanright</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Grant Dashiell</u> (Address) <u>Clara, Md</u>			
15 Filed <u>Nov. 24, 1914</u> <u>L. P. Haller</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Nov 24, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>No Physician in attendance</u>			
(Duration) _____ yrs. _____ mos. _____ ds.			
Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.			
(Signed) <u>L. P. Haller</u> Local Registrar, M. D. <u>Nov. 24, 1914</u> (Address) <u>Donkirk, Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Ellys Cemetery Clara</u>		DATE OF BURIAL <u>Nov 24, 1914</u>	
20 UNDERTAKER <u>C. G. Musick</u>		ADDRESS <u>Brivalue Md</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

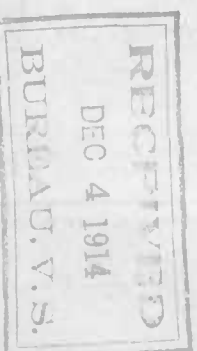
[Approved by U. S. Census and American Public Health Association.]

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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Prosy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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¹ PLACE OF DEATH 11945
County Wicomico

Village or City 7 miles south of Salisbury Md (No. 155) Registration Dist. No. 334 St.; 8 Ward)

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME James T Davis

PERSONAL AND STATISTICAL PARTICULARS

³ SEX male ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

⁶ DATE OF BIRTH no record of month, 1867
(Month) (Day) (Year)

⁷ AGE 47 yrs. 4 mos. 4 ds. OR 1 day. 4 hrs. 4 min. ?
It LESS than

⁸ OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Md

¹⁰ NAME OF FATHER John Davis
¹¹ BIRTHPLACE OF FATHER (State or country) Md

¹² MAIDEN NAME OF MOTHER Emiline Mitchell
¹³ BIRTHPLACE OF MOTHER (State or country) Md

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J M Johnson
(Address) Salisbury Md

¹⁵ Filed Nov. 20, 1914
Frederick Jones REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Nov, 19th, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from Nov 19, 1914, to Nov 19, 1914.

that I last saw him alive on Nov 19, 1914.

and that death occurred on the date stated above, at 7:15 m.

The CAUSE OF DEATH* was as follows:

Suicide
Death from Paris Green
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Signed) C R Smith, M. D.
Nov 20, 1914. (Address) Salisbury, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

¹⁹ PLACE OF BURIAL OR REMOVAL 60 DATE OF BURIAL Nov 21, 1914
Smullen Cemetery Worcester

²⁰ UNDERTAKER Halloway & Co ADDRESS Salisbury Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

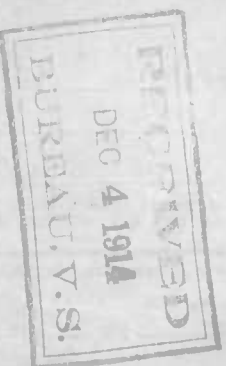
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

' PLACE OF DEATH

11946 175

County PrincipesVillage or City Salisbury (No.)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 933Camden Dist.
St. 13 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph James Ellis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)7 AGE about 6 yrs. mos. ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Delmar, Del.10 NAME OF FATHER Harry H. Ellis11 BIRTHPLACE OF FATHER (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gray B. Brown(Address) Supt of P. C. Hosp.15 Filed Nov 25, 1914 M. Gurner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 25, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from 11-24, 1914, to 11-25, 1914,that I last saw him alive on 11-25, 1914,and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows;

General peritonitis resulting from injury in automobile accident 6 weeks ago(Duration) yrs. mos. 2 ds.Contributory Voluntarily Secondary(Location) yrs. mos. 2 ds.(Signed) M. Gurner, M. D.11/25, 1914 (Address) Salisbury, Del.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 2 ds. In the State yrs. mos. 2 ds.Where was disease contracted, Delmar, Del.It not at place of death? Delmar, Del.Former or usual residence. Delmar, Del.19 PLACE OF BURIAL OR REMOVAL Delmar, Del.

DATE OF BURIAL

Nov 29th, 191420 UNDERTAKER W. S. Marvel

ADDRESS

Delmar, Del.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

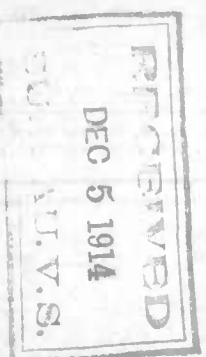
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutic," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11947
 County Wicomico
 Village or City Near Siloam (No. 28)
 2 FULL NAME Emily Fields

STATE OF MARYLAND
 CERTIFICATE OF DEATH

Registration Dist. No. 334

Trappe Dist.

St. 7 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
 (Write the word)

6 DATE OF BIRTH Sept. 20th, 1857
 (Month) (Day) (Year)

7 AGE 57 yrs. 2 mos. 3 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Wicomico Co. Md.

PARENTS
 10 NAME OF FATHER Albert Brumbley
 11 BIRTHPLACE OF FATHER (State or country) Wicomico Co. Md.
 12 MAIDEN NAME OF MOTHER Eliza Jones
 13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Fields
 (Address) Edess Md. R. 12

15 Filed Nov. 23rd, 1914
Frederick Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 23, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept., 1914, to Nov, 1914,

that I last saw him alive on Nov 21, 1914

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
 (Duration) 2 yrs. (?) mos. ds.

Contributory
 Secondary

(Signed) Geo. L. McLaughlin, M. D.
Nov 24, 1914 (Address) Frederick Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Siloam M. E. Churchyard DATE OF BURIAL Nov. 24th, 1914

20 UNDERTAKER Geo. C. Hill ADDRESS Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

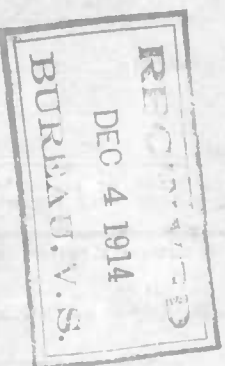
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 11948 175
 County Wicomico
Village or City Salisbury (No. Spindler Dist.; 13 Ward)
2 FULL NAME Samuel T. Gillis

STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Married
 (Write the word)
6 DATE OF BIRTH Nov 1, 1876
 (Month) (Day) (Year)
7 AGE 38 yrs. 2 ds. 1 day. 2 hrs. 0 min. ?
 If LESS than 1 day, hrs. min. ?
8 OCCUPATION
 (a) Trade, profession, or particular kind of work Mechanic
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md
10 NAME OF FATHER George W. Gillis
11 BIRTHPLACE OF FATHER (State or country) Md
12 MAIDEN NAME OF MOTHER Margaret E. Bradley
13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lottie Gable
 (Address) Mondella Springs

15 Nov 5, 1914 M. B. Burner
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 3, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1914, to Nov 3, 1914.

that I last saw him alive on Nov 3, 1914.

and that death occurred on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

(Duration) 1 yrs. 0 mos. 0 ds.
 Contributory Hit by horse & buggy
 Secondary

(Signed) A. B. Burner, M. D.
Nov 4, 1914 (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mondella Springs **DATE OF BURIAL** Nov 5, 1914

20 UNDERTAKER W. A. Conway & Co **ADDRESS** Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

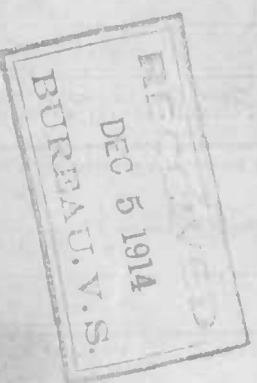
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

11949

County WicomicoVillage or City Delmar (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 331

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John M. Gordy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH

August 24, 1830
(Month) (Day) (Year)

7 AGE

84 yrs. 3 mos. 2 ds. OR 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired farmer

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Noah Gordy

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sarah Parker

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Gordy(Address) Delmar, Dela

15

Filed Nov 28, 1914 11 3 supp

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

11 26, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 20, 1914, to Nov 26, 1914.

that I last saw him alive on Nov 26, 1914.and that death occurred on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis with
Hypostatic Pneumonia

(Duration) _____ yrs. _____ mos. 10 ds.Contributory
SecondaryChronic Nephritis(Duration) 2 yrs. _____ mos. _____ ds.(Signed) J. H. Welch, M. D.191____ (Address) Delmar, Del.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Delmar M. E. Cemetery Nov 28, 1914

20 UNDERTAKER

ADDRESS

Mr. S. Marvel Delmar, Del.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the misase CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the misase CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial nephritis*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11950

County WicomicoVillage or City Mardela(No. 92)Registration Dist. No. 330

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ester A. Graham

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

Married
(Write the word)

6 DATE OF BIRTH

— — 1887
(Month) (Day) (Year)

7 AGE

78 yrs. — mos. — ds. OR — min. ?
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Maryland

10 NAME OF FATHER

John Murphy11 BIRTHPLACE OF FATHER
(State or country)Ireland

12 MAIDEN NAME OF MOTHER

Keturah Hornum13 BIRTHPLACE OF MOTHER
(State or country)Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Graham

(Address)

Mardela Ind.

15

Filed —, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

11 21, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Nov. 20, 1914, to Nov 20, 1914that I last saw her alive on 20, 1914and that death occurred on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Star pneumonia
R.C.S. (Duration) — yrs. — mos. — ds.Contributory
(Secondary)(Signed) H. B. Conway, M. D.
Nov 26, 1914 (Address) Hebron

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mardela Ind.11/22, 1914

20 UNDERTAKER

ADDRESS

A. E. Graham Mardela Ind.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

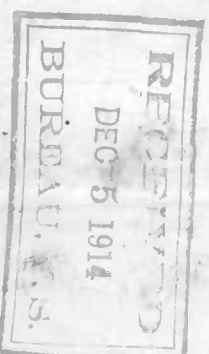
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal positions, such as "Asphyxia," "Anæmia" (imply symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11951

County

Wicomico

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

Village or City

Salisbury Md.

(No.

Parsons Dist.

St.

3 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Catharine Griffiths

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Widowed

6 DATE OF BIRTH

June 29th 1863

(Month)

(Day)

(Year)

7 AGE

57 yrs. 4 mos. 20 ds.

It LESS than
1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Housekeeping

(b) General nature of industry,
business, or establishment in
which employed (or employer)

At Home

9 BIRTHPLACE

(State or country)

Pennsylvania

PARENTS

10 NAME OF
FATHER

James McConnell

11 BIRTHPLACE
OF FATHER
(State or country)

Ireland

12 MAIDEN NAME
OF MOTHER

I Don't Know

13 BIRTHPLACE
OF MOTHER
(State or country)

Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Beulah L. Griffiths

(Address)

Salisbury Md.

15

Filed

Nov. 21, 1914

Gray Turner

REGISTRAR

①

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 19, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

October 1, 1914, to Nov 19, 1914

that I last saw her alive on Nov 19, 1914

and that death occurred on the date stated above, at 8:15 p.m.

The CAUSE OF DEATH* was as follows:

metastases from uterine
Carcinoma

(Duration) yrs. mos. ds.

Contributory
Secondary

malnutrition

(Duration) yrs. mos. ds.

(Signed) L. Morris Pritchard, M. D.

Nov 21, 1914 (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
It not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

G.A.R. Cem. Summit Hill
Carlton Co. Pa.

Nov. 23rd, 1914

20 UNDERTAKER

ADDRESS

Shipped by Geo. C. Hill Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

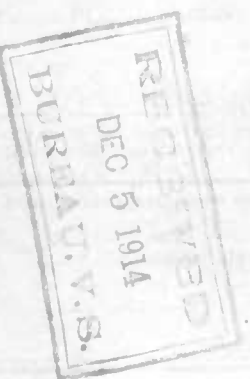
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH

County Wicomico

Village or City

Salisbury

(No.

Camden listSt. 13

Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant one name (Hawkins)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)single

6 DATE OF BIRTH

Aug131914

(Month)

(Day)

(Year)

7 AGE

yrs. 2mos. 22ds. OR

min. ?

It LESS than
1 day.....hrs.

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of Industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF
FATHERMarion S Hawkins11 BIRTHPLACE
OF FATHER
(State or country)Md12 MAIDEN NAME
OF MOTHERGoldie Hastings13 BIRTHPLACE
OF MOTHER
(State or country)Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion S Hawkins(Address) Salisbury Md

15

Nov 6, 1914 M. Burner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov51914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY That I attended deceased from

Oct 31, 1914, to Oct 31, 1914,that I last saw him alive on Oct 31, 1914and that death occurred on the date stated above, at 59 m.

The CAUSE OF DEATH* was as follows:

MalnutritionContributory
Secondary

(Duration)

yrs. 30 mos. 20 ds.

(Signed)

W. H. Jones, M. D.Nov 5, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prosser CemeteryNov 6, 1914

20 UNDERTAKER

ADDRESS

S. Holloway & CoSalisbury Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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RECEIVED
DEC 5 1914
BIRMINGHAM, ALA.

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1 PLACE OF DEATH 11953-28

County

Wicomico

Village or City

Near Salisbury Pine Bluff Sanatorium

(No. _____)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

Camden Dist.
St. 13 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lentha J. Kennerly

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Oct 14th, 1876
(Month) (Day) (Year)

7 AGE

38 yrs. 1 mos. 12 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

R. B. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Mardela Md

PARENTS

10 NAME OF FATHER

George W. Kennerly

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Emily Knowles

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ollie B. Kennerly

(Address)

Delmar, Del.

15

Nov 27th, 1914 W. B. Turner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 26th, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 23rd, 1914, to Nov. 26th, 1914that I last saw him alive on Nov. 25th, 1914

and that death occurred on the date stated above, at 8.45 A.M.

The CAUSE OF DEATH* was as follows:

Laryngeal & Pulmonary
Tuberculosis (Duration) 2 yrs. 10 mos. ds.Contributory
Secondary

Tuberculosis (Duration) 2 yrs. 10 mos. ds.

(Signed)

E. W. N. Ford, M. D.

Nov. 26th, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parsons Cem. Salisbury Md. Nov. 28th, 1914

20 UNDERTAKER

ADDRESS

Geo. L. Hill Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

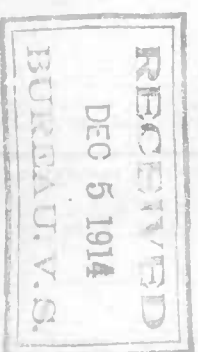
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The statement worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Repeater wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Wicomico 11954 117 STATE OF MARYLAND
 County Wicomico P. G. Hospital CERTIFICATE OF DEATH
 Village or City Salisbury (No. Camden Dist. Registration Dist. No. 333
District St.; 13 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Oakley M. Lilliston

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH Dec 20, 1891
 (Month) (Day) (Year)

7 AGE 22 yrs. 11 mos. 10 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Northampton Co. Va

10 NAME OF FATHER Edward C. Lilliston

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Boole

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred O. Lilliston(Address) Massawadox

15 Filed Nov. 30, 1914. Gray Turner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 30, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1914, to Nov. 30, 1914.

that I last saw her alive on Nov. 30, 1914.

and that death occurred on the date stated above, at 10:55 A m.

The CAUSE OF DEATH* was as follows:

General septic infection

(Duration) yrs. mos. 14 ds.

Contributory Pelvic inflammation
 Secondary

(Duration) about 2 yrs. 7 mos. 7 ds.

(Signed) M. D.

Nov. 30, 1914 (Address) Salisbury, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 9 ds. In the State yrs. mos. 9 ds.

Where was disease contracted, Northampton Co. Va
 If not at place of death?

Former or usual residence Northampton Co. Va

19 PLACE OF BURIAL OR REMOVAL Massawadox Va.

DATE OF BURIAL Dec. 2 1914. 11 A. M.

20 UNDERTAKER Geo. E. Hill

ADDRESS Salisbury

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH - 11955
 County Wisconsin (90)
 Village or City Sharptown (No. 90) St. Ward
 2 FULL NAME William M. McWilliams
 Registration Dist. No. 335
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)
 6 DATE OF BIRTH April 11, 1894
 (Month) (Day) (Year)
 7 AGE 88 yrs. 7 mos. 2 ds. OR mln. ?
 If LESS than 1 day, hrs.

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Dorchester Co.

PARENTS
 10 NAME OF FATHER William M. McWilliams
 11 BIRTHPLACE OF FATHER (State or country) Dorchester Co
 12 MAIDEN NAME OF MOTHER Mary Reed
 13 BIRTHPLACE OF MOTHER (State or country) Dorchester Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Bryan
 (Address) Federalburg, Md.

15 Filed Nov 14, 1914 Mc Williams

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 13, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1914, to Nov 13, 1914.

that I last saw him alive on Nov 12, 1914

and that death occurred on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) 10 yrs. 10 mos. 10 ds.

Contributory
 Secondary

(Duration) yrs. mos. ds.

(Signed) C. E. Jones, M. D.
Nov 13, 1914 (Address) Sharptown and

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sharptown DATE OF BURIAL Nov 14, 1914

20 UNDERTAKER W. H. Traver ADDRESS W. H. Traver W. B. Sharptown, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

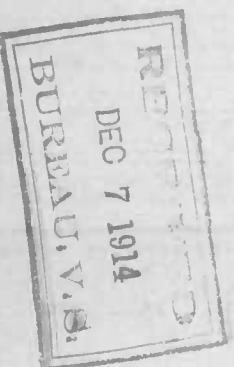
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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11956
151

1 PLACE OF DEATH
County Wicomico (Peninsula General Hospital)
Village or City Salisbury (No. Camden St St. 13th Ward)

Registration Dist. No. 333
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Male infant of Richard H. Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
6 DATE OF BIRTH <u>Nov. 2nd</u> , 1914 (Month) (Day) (Year)		
7 AGE <u>0</u> yrs. <u>0</u> mos. <u>4</u> ds. OR...min.?		It LESS than 1 day, ...hrs.
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Salisbury Md.</u>		

PARENTS	10 NAME OF FATHER <u>Richard H. Mitchell</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>Delaware</u>
	12 MAIDEN NAME OF MOTHER <u>May Dickerson</u>
	13 BIRTHPLACE OF MOTHER (State or country) <u>Delaware</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. B. Vernon
(Address) Supt. of Hospital

15 Filed Nov 6, 1914 W. B. Turner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 5, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1914, to Nov. 5, 1914, that I last saw him alive on Nov. 5, 1914, and that death occurred on the date stated above, at 2 P. m, The CAUSE OF DEATH* was as follows:

Convulsions — Cause unknown
(Duration) ... yrs. ... mos. 12 ds.

Contributory Exhaustion.
Secondary (Duration) ... yrs. ... mos. ... ds.

(Signed) D. B. Potter, M. D.
Nov. 6, 1914. (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL <u>Public Cemetery Salisbury Md.</u>	DATE OF BURIAL <u>Nov. 6th</u> , 1914
20 UNDERTAKER <u>Geo. L. Hall</u>	ADDRESS <u>Salisbury Md.</u>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH			11957		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Wicomico</u>			(151)		Registered No. <u>333</u>	
Village or City <u>Salisbury</u>			(No. <u>Church St</u>)		Parsons Dist. <u>St. 5th Ward</u>	
FULL NAME <u>infant of R. T. Matthey</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>single</u>				
6 DATE OF BIRTH <u>Nov 13</u> , 1914 (Month) (Day) (Year)						
7 AGE _____ yrs. _____ mos. <u>10</u> ds. If LESS than 1 day, _____ hrs. OR _____ min. ?						
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____						
9 BIRTHPLACE (State or country) <u>Salisbury Md</u>						
PARENTS	10 NAME OF FATHER <u>R. T. Matthey</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Chatham Va</u> <u>Pittsylvania Co</u>					
	12 MAIDEN NAME OF MOTHER <u>Eva Hastings</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Wicomico</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>R. T. Matthey</u> (Address) <u>Salisbury Md</u>						
15 <u>Nov 27</u> , 1914 <u>M. Garner</u> FILED REGISTRAR						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>November 26</u> , 1914 (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 13</u> , 1914, to <u>November 25</u> , 1914, that I last saw him alive on <u>November 25</u> , 1914, and that death occurred on the date stated above, at <u>3 P.</u> m.						
The CAUSE OF DEATH* was as follows: <u>Starvation, Infant premature</u> <u>born weak & fed improperly</u> <u>about 7 1/2 to 8 months child</u> (Duration) <u>13</u> yrs. _____ mos. _____ ds. Contributory <u>Food, Poor in Water</u> (Secondary) _____ (Signed) <u>John Standish</u> M. D. <u>Nov 27</u> , 1914 (Address) <u>Salisbury Md</u>						
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.						
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Wicomico Ind</u> <u>Forest Grove Cem</u>					DATE OF BURIAL <u>Nov 28th</u> 2 P. M., 1914	
20 UNDERTAKER <u>Geo. L. Hill</u>					ADDRESS <u>Salisbury</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

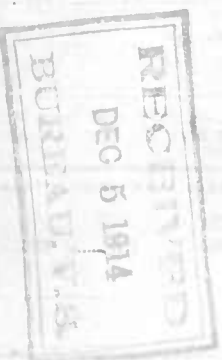
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not rainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcin-*

oma, Sarcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 11958

County

Wicomico

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

Village or City

Wango

(No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thomas Loren Mumford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

May 1, 1828

7 AGE

86 yrs 7 mos 27 ds

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer (Retired 8 yrs.)

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Worcester County

PARENTS

10 NAME OF FATHER

Jebulon Mumford

11 BIRTHPLACE OF FATHER

(State or country)

Not known

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Mumford

(Address)

Wango, Md.

15

Filed

11/28, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 27, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 11, 1914, to Nov 27, 1914

that I last saw him alive on Nov 25, 1914

and that death occurred on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis

since Nov 11, 1914

(Duration) yrs. mos. ds.

Contributory

Secondary

Paralysis

(Duration) yrs. mos. ds.

(Signed)

W. P. Waite

M. D.

Nov 27, 1914 (Address) Sales Agency

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wango, Md.

Nov 28, 1914

20 UNDERTAKER

ADDRESS

J. Ratliff Farlow Willards Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

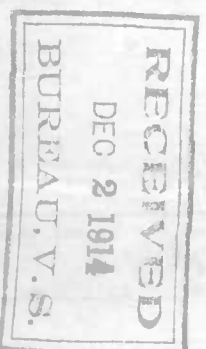
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scutlet," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misceirage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

11959

County

Village or City

2 FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 330

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

✓

6 DATE OF BIRTH

Nov

4

1914

(Month)

(Day)

(Year)

7 AGE

If LESS than

1 day, hrs.

OR min. ?

yrs.

mos.

ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Md

10 NAME OF FATHER

Henry Neil

11 BIRTHPLACE OF FATHER
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Viola Dashiell

13 BIRTHPLACE OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah Dashiell

(Address)

Mardela Spgs

15

Filed

Nov 12, 1914

J. L. English

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov

4

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory
Secondary

(Signed)

Isaac L. English, M.D.

Nov 12, 1914

(Address) Mardela Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

(P. H. H.)

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

H. P. H. Hollis

Nov 4, 1914

20 UNDERTAKER

ADDRESS

Harley Dashiell

Mardela

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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RECEIVED

DEC 5 1914

BUREAU. V. S.

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1 PLACE OF DEATH County <u>County McOmico</u> 11980 <u>5</u>			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Mardela Spgs</u> (No. <u>330</u>)			Registration Dist. No. <u>330</u>		
2 FULL NAME <u>Infant Still-Born</u> <u>Neil</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>—</u>	16 DATE OF DEATH <u>Nov 4</u> , 191 <u>4</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Nov 4</u> , 191 <u>4</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Still Born</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory (Secondary) _____ (Signed) <u>Isaac L. English Reg.</u> , M. D. , 191____ (Address) _____		
7 AGE _____ yrs. _____ mos. <u>4</u> ds. OR LESS than 1 day, _____ hrs. OR _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>md</u>					
PARENTS	10 NAME OF FATHER <u>Henry Neil</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>md</u>				
	12 MAIDEN NAME OF MOTHER <u>Viola - Dashiell</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sarah - Dashiell</u> (Address) <u>Mardela Spgs</u>			18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____		
15 Filed <u>Nov 12</u> , 191 <u>4</u> <u>J. L. English</u> <u>4</u> REGISTRAR			19 PLACE OF BURIAL OR REMOVAL <u>Pea - Hill</u> DATE OF BURIAL <u>Nov 4</u> , 191 <u>4</u> 20 UNDERTAKER <u>Harley - Dashiell</u> ADDRESS <u>Mardela md</u>		

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H. N.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

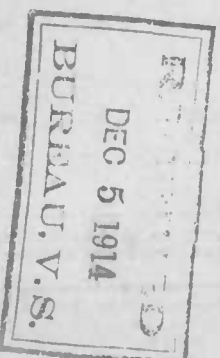
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1 PLACE OF DEATH 11961
County Wicomico

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 334

Village or City Salisbury (No. 28) St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edward J. D. Pitts

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Mar 20, 1882
(Month) (Day) (Year)

7 AGE 22 yrs. 7 mos. 21 ds. IF LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Taylor
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) McL

10 NAME OF FATHER Elijah B Pitts

11 BIRTHPLACE OF FATHER (State or country) McL

12 MAIDEN NAME OF MOTHER Mary A Crawford

13 BIRTHPLACE OF MOTHER (State or country) McL

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elijah B Pitts

(Address) Salisbury Md

15 Filed Nov. 13, 1914

J. Rodney Jones REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 12, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1914
191 to Nov 11, 1914

that I last saw him alive on Nov 11, 1914

and that death occurred on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Phtusis Phlmonalis (Duration) 2 yrs. 1 mos. 1 ds.

Contributory
Secondary

Tuberculosis (Duration) 2 yrs. 1 mos. 1 ds.

(Signed) Geo. H. Todd M. D.

Nov 13, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death Nov 13, 1914 yrs. 7 mos. 21 ds. In the State Nov 13, 1914 yrs. 7 mos. 21 ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hastings Cemetery, Salisbury Md. Nov. 13, 1914

20 UNDERTAKER ADDRESS

Holloway & Co., Salisbury, Md.

1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

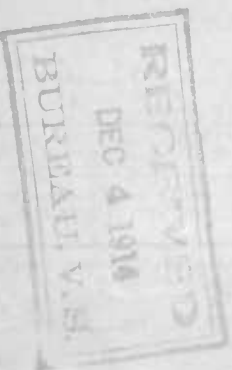
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH			11962		STATE OF MARYLAND	
County <u>M. isisno</u>			(No. <u>1510</u>)		CERTIFICATE OF DEATH	
Village or City <u>San Antonio</u>			(No. _____)		Registration Dist. No. <u>331</u>	
2 FULL NAME <u>Forrest Washington Robinson</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>				
6 DATE OF BIRTH <u>August 12, 1914</u> (Month) (Day) (Year)						
7 AGE yrs. <u>3</u> mos. <u>9</u> ds. If LESS than 1 day, hrs. OR min. ?						
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer)						
9 BIRTHPLACE (State or country) <u>M. isisno Maryland</u>						
PARENTS						
10 NAME OF FATHER <u>Nobles E Robinson</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>						
12 MAIDEN NAME OF MOTHER <u>Pheney Ryan</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Delaware</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Nobles E Robinson</u> (Address) <u>Maddala St. Md</u>						
15 Filed _____, 191____ REGISTRAR						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Nov 21, 1914</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 12, 1914</u> , to <u>Nov 21, 1914</u> , that I last saw him alive on <u>Nov 21, 1914</u> , and that death occurred on the date stated above, at <u>5 P. M.</u> , The CAUSE OF DEATH* was as follows: <u>Marasmus</u> (Duration) yrs. ____ mos. ____ ds. Contributory (Secondary) <u>Mrs. E. L. Robinson</u> (Signed) <u>J. D. Campbell</u> M. D. <u>Nov 21, 1914</u> (Address) <u>San Antonio Md</u>						
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.						
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. ____ mos. ____ ds. In the State yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence						
19 PLACE OF BURIAL OR REMOVAL <u>Offical Baptist Church</u>						
DATE OF BURIAL <u>Nov 23, 1914</u>						
20 UNDERTAKER <u>Lake Reservoir</u>						
ADDRESS <u>Maddala St. Md</u>						
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.						

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

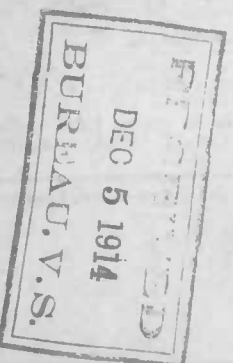
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—(oil mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Mecomico</u>		11963 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u> (No. <u>Cannister St.</u> 13 Ward)		Registration Dist. No. <u>333</u>	
2 FULL NAME <u>Hester Humphreys Ruark</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, <input checked="" type="checkbox"/> <u>Single</u> MARRIED, <input type="checkbox"/> WIDOWED, <input type="checkbox"/> ORDIVORCED, <input type="checkbox"/> (Write the word)	
6 DATE OF BIRTH <u>August 76</u> , 18 <u>76</u> (Month) (Day) (Year)			
7 AGE <u>38</u> yrs. <u>2</u> mos. <u>23</u> ds.		If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Merantile business</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Hardware</u>			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Geo H W Ruark</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Georgia Lowe</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henry W Ruark</u> (Address) <u>Salisbury Md</u>			
15 <u>Nov 19</u> , 191 <u>4</u> <u>A. P. Sumner</u> Filed REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Nov 18</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>May</u> , 191 <u>4</u> to <u>Nov 18</u> , 191 <u>4</u> , that I last saw him alive on <u>Nov 18</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>9 P</u> m. The CAUSE OF DEATH* was as follows: <u>Chronic interstitial nephritis</u> <u>Several years</u> (Duration) yrs. mos. ds. Contributory <u>None</u> Secondary <u>None</u> (Duration) yrs. mos. ds. (Signed) <u>M. D.</u> <u>Nov 19</u> , 191 <u>4</u> (Address) <u>Salisbury Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.....			
19 PLACE OF BURIAL OR REMOVAL <u>Parsons Cem. Salisbury Md.</u>		DATE OF BURIAL <u>Nov 21</u> at <u>11 A. M.</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Geo. C. Hill</u>		ADDRESS <u>Salisbury Md.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
DEC 5 1916
BUREAU, U.S.

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1 PLACE OF DEATH

County

Wicomico 1964

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

Village or City

Salisbury (No. Peninsula Hosp. St. 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Washington Savage

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

a. a

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

married

6 DATE OF BIRTH

~ ~ ~ 1884
(Month) (Day) (Year)

7 AGE

30 yrs ~ mos ~ ds. OR 1 day ~ hrs. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Virginia

PARENTS

10 NAME OF FATHER

Dennis B. Savage

11 BIRTHPLACE OF FATHER
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Anne Watson

13 BIRTHPLACE OF MOTHER
(State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dennis B. Savage

(Address)

Mappsville Va.

15

Filed

Nov 10, 1914. May Turner.

Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 6, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov. 1, 1914, to Nov. 9, 1914.

that I last saw him alive on Nov. 9, 1914.

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. mos. 2 ds.

Contributory
Secondary

Acute nephritis

(Duration) yrs. mos. 3 ds.

(Signed)

J. M. D.

Nov. 10, 1914 (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 10 ds. In the State yrs. mos. 10 ds.

Where was disease contracted? Accomack Co. Va.

If not at place of death? Former or usual residence Accomack Co. Va.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mappsville, Va.

Nov 11, 1914

20 UNDERTAKER

ADDRESS

Jas. F. Stewart

Salisbury Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

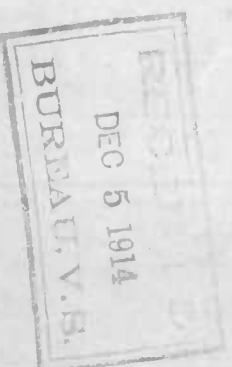
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11965

County WicomicoVillage or City Salisbury (No. 91)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 334

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St. 9 Ward2 FULL NAME Samuel W O Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Sept 3, 1914
(Month) (Day) (Year)

7 AGE 2 yrs. 2 mos. 2 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Levin Smith

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Elza

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Levin Smith(Address) Salisbury Md

15 Filed Nov 7, 1914
Thaddeus Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 5th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

I saw this child once, before death, from pneumonia
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory Cold
Secondary

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) C R Smith, M. D.

Nov 6th, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Peters Field Nov 7, 1914

20 UNDERTAKER ADDRESS

Holloway & Co Salisbury Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

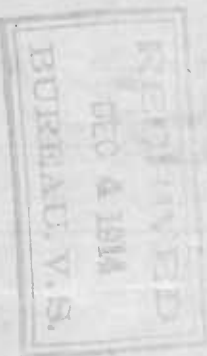
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Wicomico

11966

(9)

Village or City

Sharptown

(No.)

St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 1335

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Eleanor Smoot.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

July 30, 1907
(Month) (Day) (Year)

7 AGE

7 yrs. 3 mos. 28 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ohio.

PARENTS

10 NAME OF FATHER

Homer Smoot

11 BIRTHPLACE OF FATHER

(State or country)

Dorchester Co

12 MAIDEN NAME OF MOTHER

Geneva Gordy.

13 BIRTHPLACE OF MOTHER

(State or country)

Dorchester Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Homer Smoot

(Address)

Sharptown.

15

Filed

728

1914

W. C. Mann

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 28, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 23, 1914, to Nov 28, 1914.

that I last saw her alive on Nov 28, 1914.

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) yrs. mos. 5 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

C. E. James

M. D.

Nov 28, 1914 (Address) Sharptown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Galestown Md

Nov 28, 1914

20 UNDERTAKER

ADDRESS

W. H. Gravenor & Co Sharptown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

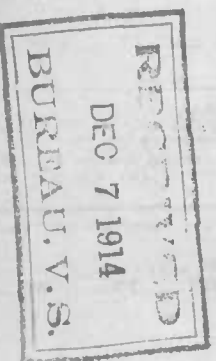
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases, resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIO- LENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci- dent*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

11967

County WicomicoSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 334Village or City Salisbury (No. 9) St. _____ Ward _____

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant of James W. Taylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Nov 16, 1914
(Month) (Day) (Year)

7 AGE _____ It LESS than 1 day, _____ hrs. OR _____ min. ?
_____ yrs. _____ mos. _____ ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Wicomico Co

PARENTS
10 NAME OF FATHER James W. Taylor
11 BIRTHPLACE OF FATHER (State or country) Wicomico Co
12 MAIDEN NAME OF MOTHER Aurelia Garry
13 BIRTHPLACE OF MOTHER (State or country) Wicomico Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James W. Taylor
(Address) Salisbury Md

15 Filed Nov. 17, 1914
John Rodney Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 16, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from before to birth, 191____, that I last saw him _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Still Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Signed) Jos. R. Needham, M. D.
Nov. 17, 1914 (Address) Frederick Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____
If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Allen M. E. Churchyard DATE OF BURIAL Nov. 17th, 1914
20 UNDERTAKER George L. Hill ADDRESS Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

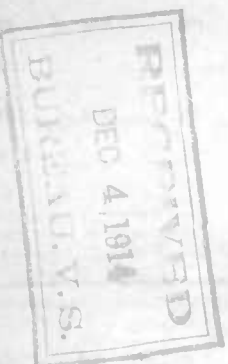
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1 PLACE OF DEATH 11968 120
 County Wicomico
 Village or City Pittsville (No. _____, _____ St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 332

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Isaac Jacob Truitt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
 (Write the word)

6 DATE OF BIRTH 12 - 28 - 1831
 (Month) (Day) (Year)

7 AGE 82 yrs. 10 mos. 10 ds. OR 1 day, _____ hrs. _____ min. ?
 It LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Md.

PARENTS
 10 NAME OF FATHER Matthias Truitt
 11 BIRTHPLACE OF FATHER (State or country) Md.
 12 MAIDEN NAME OF MOTHER Lanta Gault
 13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. E. Truitt(Address) Pittsville, Md.

15 Filed 11/10, 1914 H. J. Truitt
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 8, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1914 to Nov. 7, 1914

that I last saw him alive on Nov. 7, 1914and that death occurred on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) _____ yrs. _____ mos. _____ ds.
 Contributory Pulmonary edema
 Secondary

(Signed) L. C. Grueney, M. D.
Nov. 8, 1914 (Address) Pittsville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Grace M. P. Cemetery DATE OF BURIAL " / " , 1914

20 UNDERTAKER Wm. P. Parsons ADDRESS Whitesville
Del.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

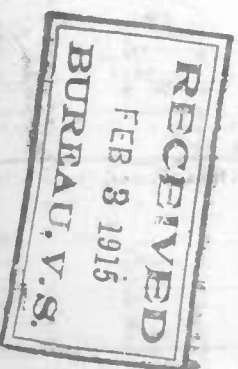
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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about out
to be signed
on this
form.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

11969

County

Wilcomico

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

334

Village or City

Allen

(No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary E Tull

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

A A

5 SINGLE,
MARRIED,
WIDDED,
ORDIVORCED
(Write the word)

married

DATE OF BIRTH

Not Known

1867

(Month)

(Day)

(Year)

7 AGE

47

yrs.

mos.

ds.

If LESS than
1 day.....hrs.
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Gen Housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF
FATHER

Wesley Brewington

PARENTS

11 BIRTHPLACE
OF FATHER
(State or country)

Maryland

12 MAIDEN NAME
OF MOTHER

Ester Ferrell

13 BIRTHPLACE
OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter King

(Address)

Allen Md

15

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov

17

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

March

1914

to Nov

12

1914

that I last saw her alive on

Nov

10

1914

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

Contributory
Secondary

(Duration) _____ yrs. mos. ds.

(Signed)

J. P. McLaughlin

M. D.

Nov 14, 1914

(Address)

Fruitland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Allen Cemetery

Nov 16, 1914

20 UNDERTAKER

ADDRESS

J. Stewart Salisbury Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

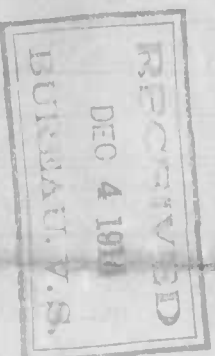
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Wicomico</u>		11970 <u>154</u>		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>335</u>	
Village or City <u>Sharptown</u>		(No. <u>6</u>)		St. <u> </u> Ward <u> </u>	
2 FULL NAME <u>Nancy S. Walker</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>			
6 DATE OF BIRTH <u>Oct 5, 1879</u> (Month) (Day) (Year)					
7 AGE <u>85</u> yrs. <u>27</u> ds. <u>OR</u> min. ? If LESS than 1 day, hrs.					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>James W. Bradley</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Jane Collins</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Anna McWilliams</u> (Address) <u>Sharptown</u>					
15 Filed <u>Nov 4</u> , 191 <u>4</u> <u>W. C. Mann</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov 2</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 21</u> , 191 <u>4</u> , to <u>Nov 1</u> , 191 <u>4</u> , that I last saw her alive on <u>Nov 1</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>8</u> a.m., The CAUSE OF DEATH* was as follows: <u>Anemia</u> <u>Followed by failure heart</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds.					
Contributory <u> </u> Secondary <u> </u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds.					
(Signed) <u>G. R. Asler</u> , M. D. <u>Nov 4</u> , 191 <u>4</u> (Address) <u>Baldestown</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u> </u>					
19 PLACE OF BURIAL OR REMOVAL <u>Sharptown</u>				DATE OF BURIAL <u>Nov 4</u> , 191 <u>4</u>	
20 UNDERTAKER <u>W. H. Traveno & Co</u>				ADDRESS <u>Sharptown Md</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

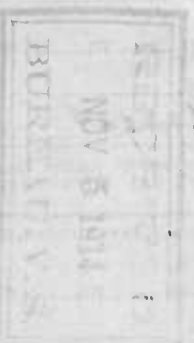
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* as such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

11971

County MicominiesSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 338Village or City Hebron (No. _____, St. _____ Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ralph Watson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Aug 12, 1908
(Month) (Day) (Year)7 AGE 6 yrs. 3 mos. 2 ds. OR 1 day, 2 hrs. 2 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) " "

9 BIRTHPLACE (State or country) Hebron Micominies Co

PARENTS
10 NAME OF FATHER Eura Watson
11 BIRTHPLACE OF FATHER (State or country) Moreester Co
12 MAIDEN NAME OF MOTHER Ida Phillips
13 BIRTHPLACE OF MOTHER (State or country) Micominies Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eura Watson

(Address)

Hebron Md15 Filed Nov. 14, 1914 H. S. Phillips
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 13, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1914 to Nov 13, 1914that I last saw him alive on Nov 13, 1914and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Spasmodic Croup, & Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Conaway, M. D.
Nov 14, 1914 (Address) Hebron Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
if not at place of death?Former or
usual residence19 PLACE OF BURIAL OR REMOVAL Hebron Cemetery DATE OF BURIAL Nov 15, 191420 UNDERTAKER George C. Hill ADDRESS Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

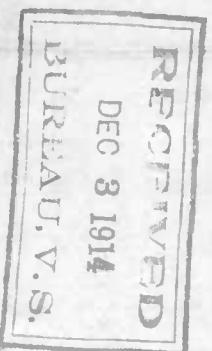
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oma, *Sarcoma*, etc., of....." (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		11972		STATE OF MARYLAND	
County <u>Monroe</u>		(90)		CERTIFICATE OF DEATH	
Village or City <u>Sharptown</u>		(No. _____)		Registration Dist. No. <u>335</u>	
2 FULL NAME <u>Caleb Tighman Wheatley</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 STATUS <u>married</u> MARRIED, <u>married</u> WIDOWED, <u>married</u> ORDIVORCED, <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>Oct 15 1843</u> <u>Nov 4 1843</u> (Month) (Day) (Year)					
7 AGE <u>71</u> yrs. <u>19</u> mos. <u>19</u> ds.		If LESS than 1 day, _____ hrs. _____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Ind.</u>					
PARENTS	10 NAME OF FATHER <u>William A. Wheatley</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>				
	12 MAIDEN NAME OF MOTHER <u>Mary Ann Davis</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Ind.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>James J. Wheatley</u>					
(Address) <u>Cash Grove Del.</u>					
15 Filed <u>Nov 6 1914</u> <u>H. C. Mann</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov 4 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 25 1914</u> to <u>Nov 4 1914</u> , that I last saw him alive on <u>Nov 3 1914</u> , and that death occurred on the date stated above, at <u>9 a. m.</u> , The CAUSE OF DEATH* was as follows:					
<u>Acute Bronchitis</u>					
(Duration) _____ yrs. _____ mos. <u>10</u> ds.					
Contributory Secondary _____					
(Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>C. E. Jones</u> , M. D. <u>Nov. 6 1914</u> (Address) <u>Sharptown Ind.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)					
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.					
Where was disease contracted, If not at place of death? _____					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Cokesbury M. E. Church</u> <u>Dorchester S. Rd.</u>			DATE OF BURIAL <u>Nov. 6 1914</u>		
20 UNDERTAKER <u>J. T. Crampton & Son</u>			ADDRESS <u>Federalburg Ind.</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED
DEC 7 1914
BUREAU, V. S.

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PLACE OF DEATH 11973

County

Wicomico

Village or City

Salisbury

(No.

Carmen

St.

13 Ward)

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Annette Lower White

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH June 18th, 1843 (Month) (Day) (Year)

7 AGE 71 yrs. 4 mos. 28 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER George Vickers

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Mansfield

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Christian White

(Address)

Salisbury Md.

15 Nov 11, 1914 N. P. Sumner REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 11, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1914, to Nov 10, 1914, that I last saw her alive on Nov. 10, 1914

and that death occurred on the date stated above, at 2 a. m. The CAUSE OF DEATH* was as follows:

Infinites a
E. Phantasia (Duration) 1 yrs. - mos. - ds.
Contributory Partial Hemiplegia + Carcinoma of right breast.
Secondary (Duration) 1 yrs. 11 mos. - ds.
(Signed) Geo. H. Ladd, M. D.
Nov. 11, 1914 (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 3:30 PM
Payson Cem. Salisbury Md. Nov. 12, 1914

20 UNDERTAKER ADDRESS
Geo. C. Hill Salisbury Md.

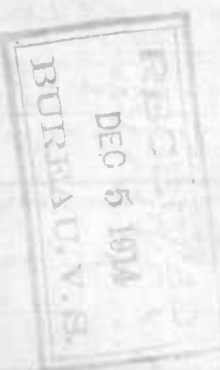
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11974

County WicomicoSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Salisbury (No. Parkers Post St.; 5 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sidney A. White

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Mar 24, 1841
(Month) (Day) (Year)

7 AGE 73 yrs. 7 mos. 18 ds. 1 LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired Sea Captain
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Piper

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest L. White(Address) Salisbury Md

15 Nov 14, 1914 W. B. B. B.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Nov. 12, 1914, to Nov. 13, 1914,

that I last saw him alive on Nov. 12, 1914

and that death occurred on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Contributory Bed sores & pneumonia
Secondary Ordinary

(Signed) W. B. B. B., M. D.
Nov 13, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Brown Cemetery Nov 15, 1914

20 UNDERTAKER ADDRESS

Ballouway Salisbury Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

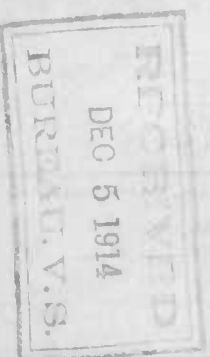
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH		11975		79		STATE OF MARYLAND CERTIFICATE OF DEATH	
County		Wicomico				Registration Dist. No. 336	
Village or City		Delmar		(No.)		St.; Ward)	
2 FULL NAME		Margaret Williams					
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)					
Female	White	Widowed					
6 DATE OF BIRTH							
May 8, 1840		(Month) (Day) (Year)					
7 AGE		If LESS than 1 day, hrs. min. ?					
74 yrs. 6 mos. 15 ds.							
8 OCCUPATION							
(a) Trade, profession, or particular kind of work		Housekeeper					
(b) General nature of industry, business, or establishment in which employed (or employer)							
9 BIRTHPLACE (State or country)		Wales					
PARENTS	10 NAME OF FATHER	Hugh Jones					
	11 BIRTHPLACE OF FATHER (State or country)	Wales					
	12 MAIDEN NAME OF MOTHER	I have no knowledge of it					
	13 BIRTHPLACE OF MOTHER (State or country)	Probably Wales					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE							
(Informant)		G. H. Williams					
(Address)		Delmar Del. Shipped to					
15							
Filed		Mar 25, 1914 W. S. Jones					
REGISTRAR		Shipped by Geo. C. Hill Salisbury Md.					
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH		11 23, 1914 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from Mar 22, 1914, to Mar 23, 1914, that I last saw him alive on Mar 22, 1914, and that death occurred on the date stated above, at 9 A. M. The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia							
		(Duration) yrs. mos. ds.					
Contributory Secondary		Pneumonia, heart trouble					
(Signed)		J. H. Jones, M. D.					
Mar 23, 1914		(Address) Delmar, Del.					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)							
At place of death		yrs. mos. ds.		In the State		yrs. mos. ds.	
Where was disease contracted, if not at place of death? Former or usual residence							
19 PLACE OF BURIAL OR REMOVAL		DATE OF BURIAL					
Shipped to Neenah Wisconsin		Nov. 25th, 1914					
20 UNDERTAKER		ADDRESS					
Shipped by Geo. C. Hill		Salisbury Md.					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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